Washington State Health Care Authority

Health Reform Implementation in Washington State

Valley View – Health Reform Symposium
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Topics for Today

ACA Coverage Opportunities

Initial Estimates of Medicaid Expansion

Ongoing Medicaid Expansion Policy Discussions

Complementary Reform Efforts

ACA Coverage Opportunities

The Supreme Court Decision

A divided Supreme Court ruled that:

- **The Affordable Care Act (ACA) requirement for individuals to have insurance or pay a tax penalty is constitutional.**

- **States can choose not to expand Medicaid to cover all state residents under 133% FPL, without risking federal funding for their entire Medicaid program.**

"The Affordable Care Act's requirement that certain individuals pay **a financial penalty for not obtaining health insurance may reasonably be characterized as a tax.** Because the Constitution permits such a tax, it is not our role to forbid it, or to pass upon its wisdom or fairness."

– Chief Justice Roberts in Majority Opinion

"In this case, the financial 'inducement' Congress has chosen is **much more than 'relatively mild encouragement'—it is a gun to the head**."

– Chief Justice Roberts in Majority Opinion

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The Decision's Implications for Medicaid

States May Opt Out of Medicaid Expansion

The Balance of ACA Medicaid Provisions Stand

- **Simplification of Eligibility**
- **Streamlining of Existing Programs**
- **Maintenance of Effort**
- **Drug Rebates in Medicaid Managed Care**
- **DSH Payment Reductions**
- **Delivery System Reform**
- **Primary Care Rate Increase**

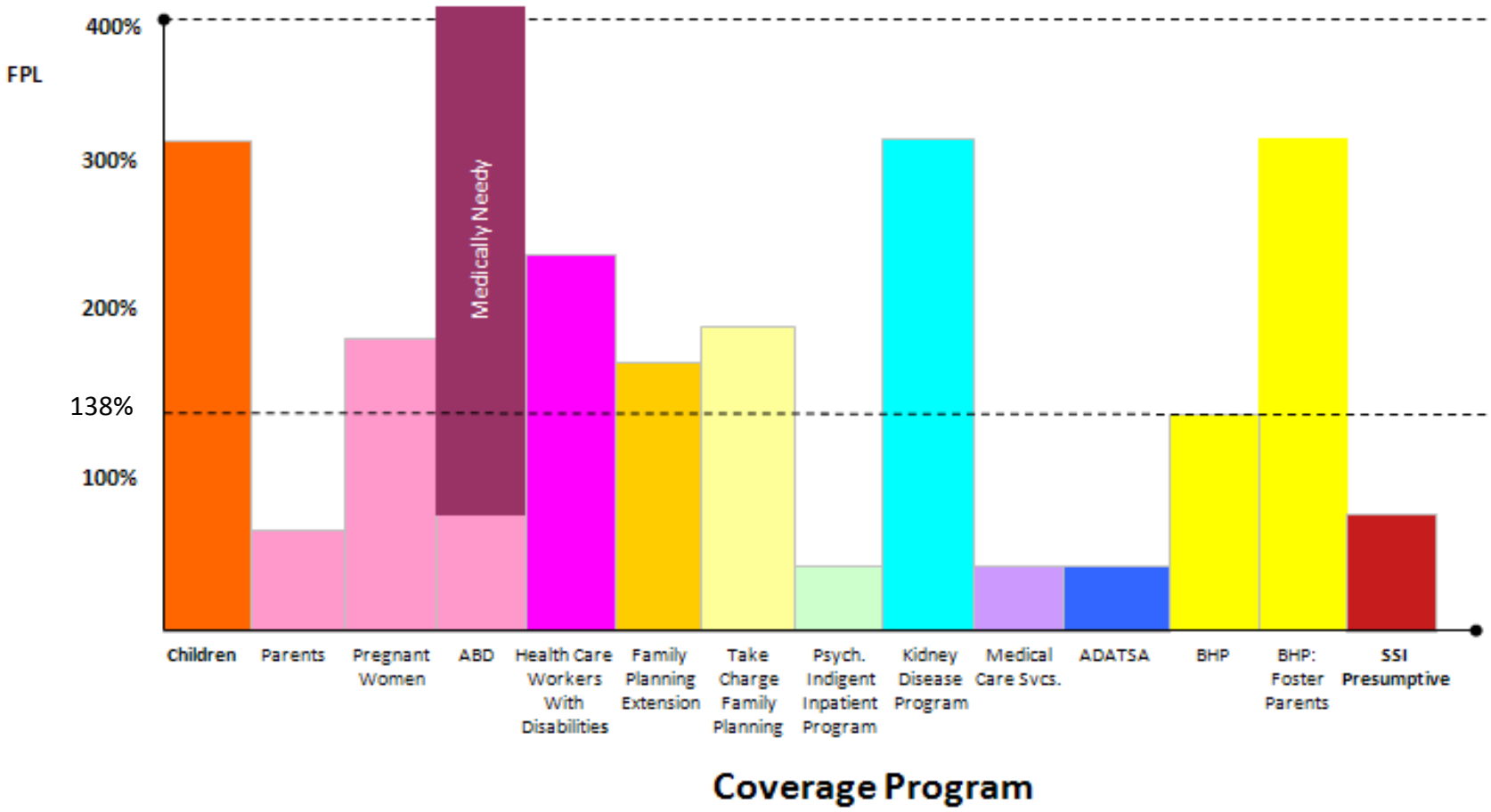
Context - Today's Medicaid Covers…

- Children – 300% of the federal poverty level (FPL);
- Pregnant women – 185% FPL;
- Families (parents and caretaker relatives) – ~40% FPL;
- Aged, blind, disabled adults - ~75% FPL

- Childless adults *may* be served in optional programs (e.g., Basic Health, Medical Care Services, ADATSA etc.)

- Today, Washington's Medicaid/CHIP programs cover ~1.16 million lives

Today's Washington State Landscape



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2014 Medicaid Coverage

- Option to expand Medicaid to 138% of the FPL for adults under age 65 not receiving Medicare* - based on Modified Adjusted Gross Income (MAGI)
  - **MAGI** will determine eligibility for children, pregnant women and parents and all adults in the new adult category
  - **Non-MAGI** (classic) Medicaid eligibility standards will still apply to aged, blind, disabled, SSI, & foster children – ACA doesn't impact these groups

- Washington's new adult group will include:
  - **Childless adults** with incomes below 138% of the FPL
  - **Parents** with incomes between ~40% and 138% of the FPL

* The ACA's "133% of the FPL" = 138% of the FPL because of a 5% across-the-board income disregard

Federal Poverty Levels and Annual Income (2012)

Federal Poverty Level	Annual Income: Individual	Annual Income Level: Family of 3
100%	$11,170	$19,090
133%	$14,856	$25,390
138%	$15,415	$26,344
200%	$22,340	$38,180
300%	$33,510	$57,270
400%	$44,680	$76,360

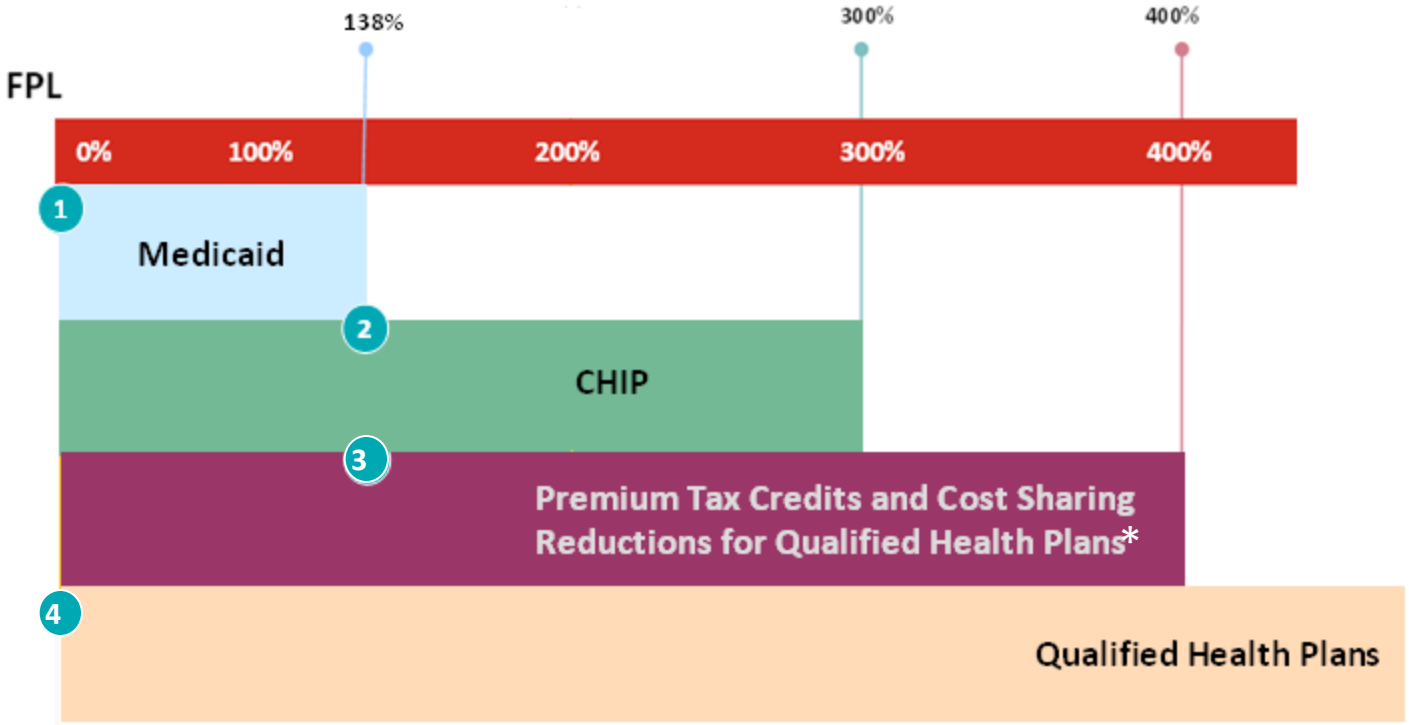
Enhanced Federal Funding for New Adult Group

- Newly eligible parents and childless adults include those who are:
  - under 65 years old
  - not pregnant
  - not entitled to Medicare
  - not in an existing Medicaid category (e.g. children, pregnant women, aged, blind and disabled)

- Enhanced federal funding for costs of newly eligible adults:

Enhanced Match	2014	2015	2016	2017	2018	2019	2020 +
State Share	0%	0%	0%	5%	6%	7%	10%
Federal Share	100%	100%	100%	95%	94%	93%	90%

2014 ACA Continuum of "Insurance Affordability Programs"



* Federal Basic Health Plan Option for individuals with incomes between 138% and 200% of the FPL will not be available in 2014.

The Exchange: A Doorway to Coverage

Think: Amazon.com or Expedia...
A simple way to shop for health insurance

1. Find out your eligibility for Medicaid, CHIP, and Premium Tax Credits/Cost Sharing Reductions
2. Find out your eligibility for Qualified Health Plans
3. Compare your plan options
4. Choose a plan and enroll!

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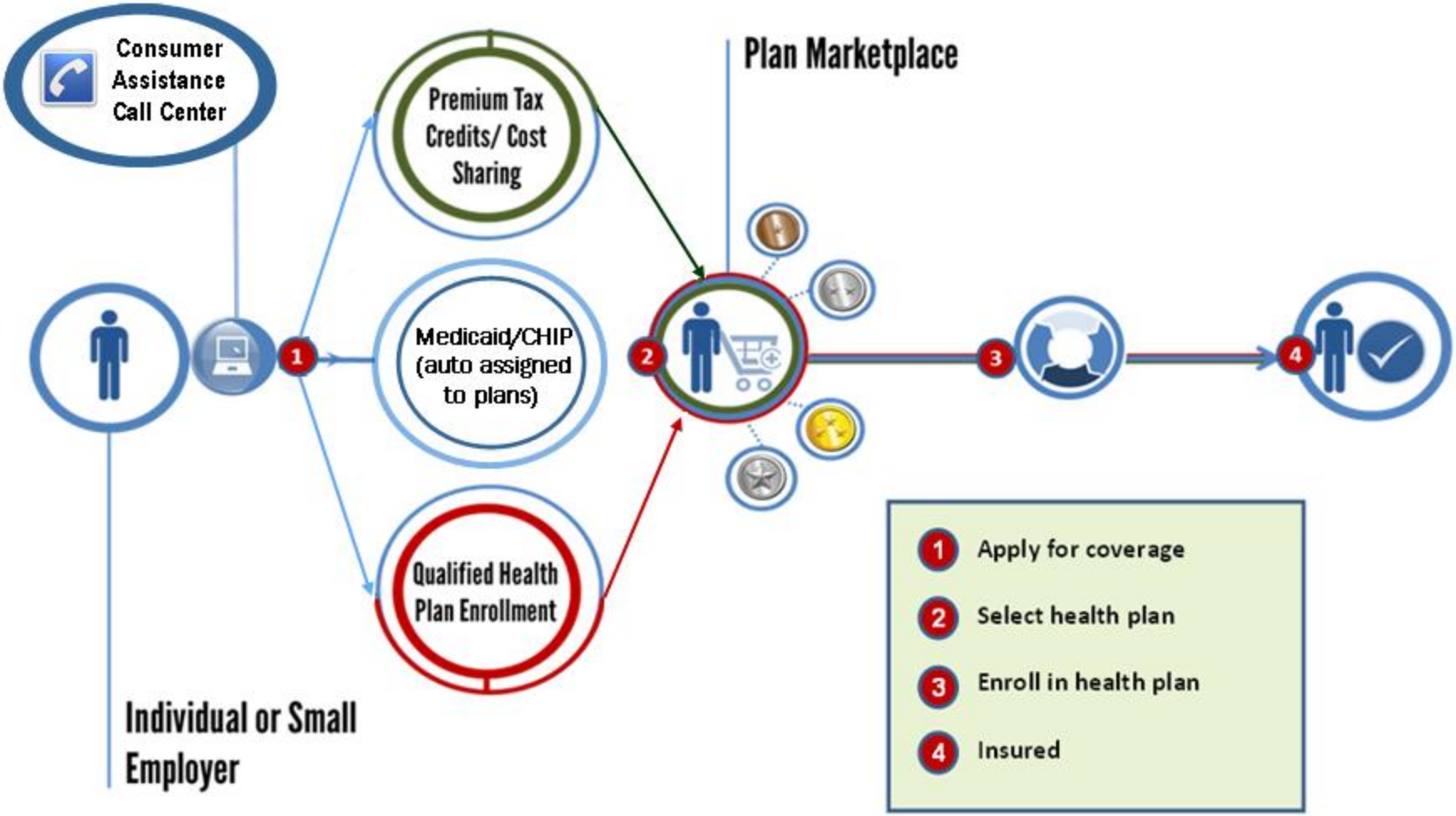
The Exchange: One-Stop Shopping for Health Insurance



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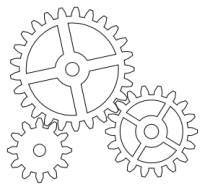
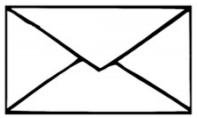
Applying for Insurance is Easy

Application Must Be



Single and streamlined, for use enrolling into Medicaid, CHIP, premium tax credits/ cost sharing reductions, and qualified health plans



Accepted via: website, phone, mail, in-person, and other common electronic means

Federally approved (if using state-specific form, rather than Federal model)

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Premium Tax Credits/Cost Sharing Reductions

Individuals up to 400% of the FPL who are ineligible for Medicaid are eligible for premium tax credits and cost sharing reductions, determined by an individual's income levels:

Premium Tax Credits:

Income Level	Premium as Percent of Income
Up to 133% FPL	2% of income
133-150% FPL	3-4% of income
150-200% FPL	4-6.3% of income
200-250% FPL	6.3-8.05% of income
250-300% FPL	8.05-9.5% of income
300-400% FPL	9.5% of income

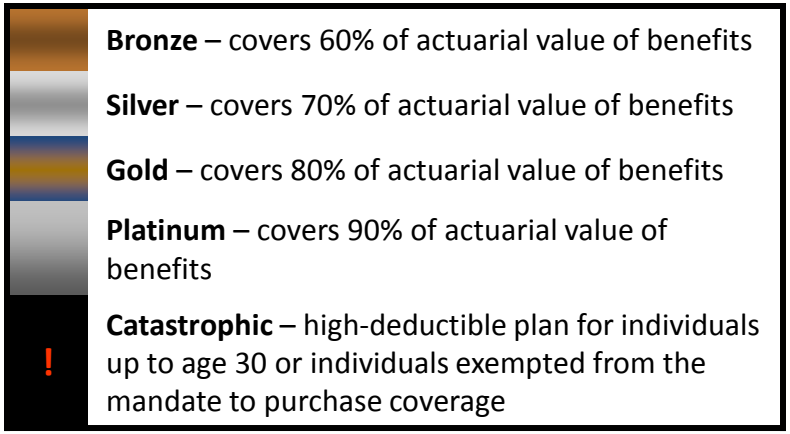
Cost Sharing Reductions:

Income Level	Reduction in Out-of-Pocket Liability
100-150% FPL	94% of the actuarial value*
150-200% FPL	87% of the actuarial value
200-250% FPL	73% of the actuarial value

*Of the second lowest cost Silver plan

Qualified Health Plans

- **Qualified Health Plans (QHPs) will be available to individuals and small employers in the Exchange**
- **The Exchange will:**
  - Set standards for QHPs
  - Certify participating plans, and
  - Rank plans from **bronze to platinum** to indicate what level of coverage the plan offers



- **QHPs must:**
  - Provide "Essential Health Benefits" (EHBs)
  - Ensure sufficient choice of providers
  - Be accountable for performance on clinical quality measures and patient satisfaction
  - Implement a quality improvement strategy
  - Provide accurate and standardized consumer information
  - Be a private health insurance plan

Private Market Reforms

- Elimination of annual/lifetime limits
- Elimination of pre-existing conditions exclusion
- Elimination of rescissions

- Expansion of dependent coverage up to age 26
- Coverage of preventive health services with no cost-sharing
- Uniform explanation of coverage documents
- Reporting requirements regarding quality of care
- Process to review unreasonable rate increases by health plans
- New standards related to medical loss ratios and subsequent rebates to plan participants

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Consumer Assistance Will Be Available

To reach the ~1,000,000 uninsured Washington residents, the State will rely on:

Navigators, Agents and Brokers: will provide help to consumers and small businesses with enrolling into coverage on the Exchange; provide advice to consumers about their enrollment options and premium tax credits; and make referrals of complex cases to Consumer Assistance Programs

Community-Based Organizations: Continued partnership with existing community-based network

Call Center: Toll-Free Hotline operated by the Exchange to provide insurance application assistance

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Initial Estimates of Medicaid Expansion

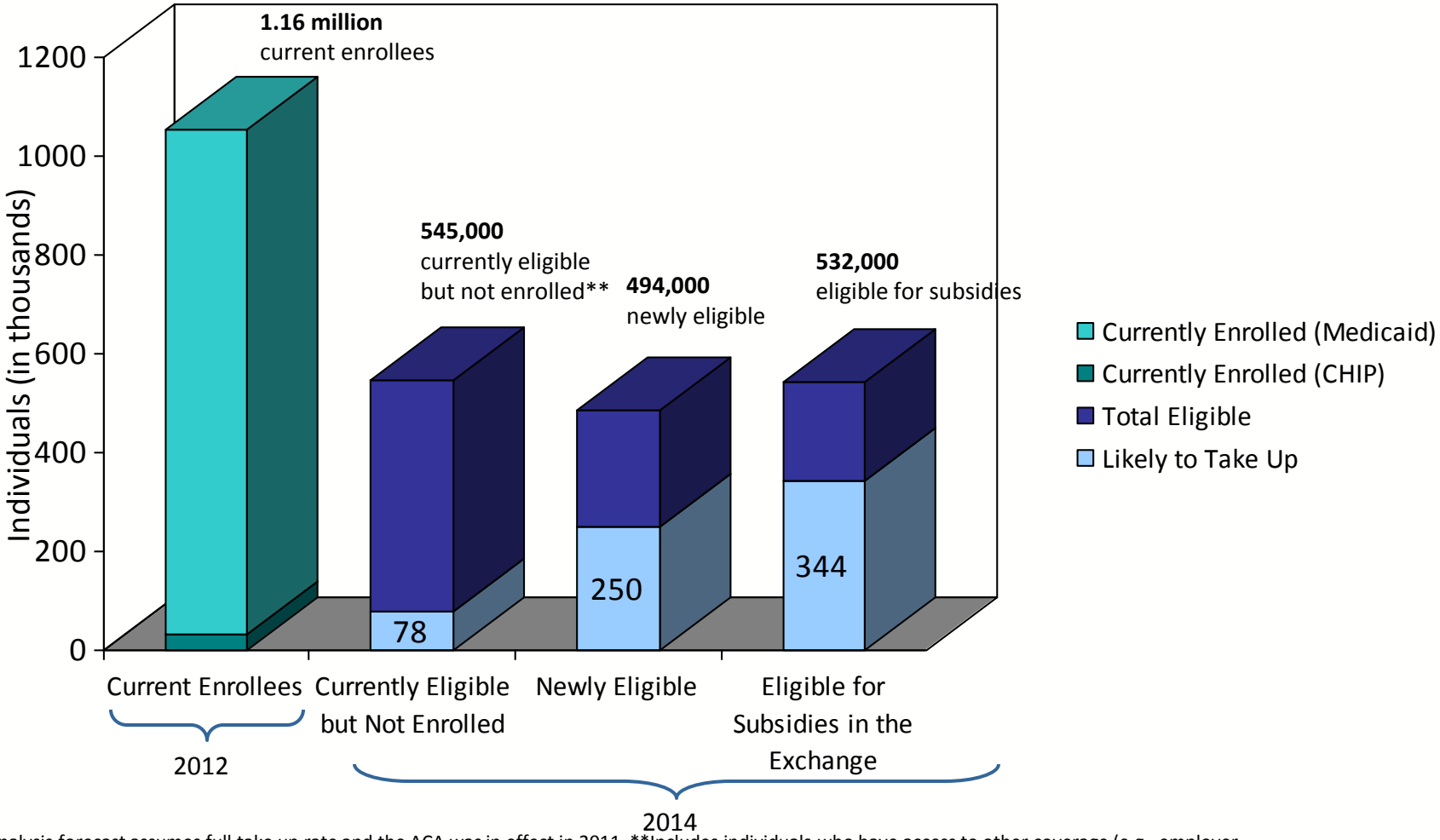
Initial Enrollment Modeling

- Washington contracted with Urban Institute to model estimates of potential enrollment impact

…as if the Affordable Care Act were fully implemented in 2011

- Analysis includes:
  - Characteristics of new Medicaid enrollees
  - (e.g., age, health status, geographic location)
  - Projected eligibility counts
  - Projected enrollment & ramp-up
- Report available at: **http://www.hca.wa.gov/hcr/resources.html**

Post Implementation of the ACA: Subsidized Coverage Landscape in Washington



Note: Analysis forecast assumes full take up rate and the ACA was in effect in 2011. **Includes individuals who have access to other coverage (e.g., employer sponsored insurance). Sources: The ACA Medicaid Expansion in Washington, Health Policy Center, Urban Institute (May 2012); The ACA Basic Health Program in Washington State, Health Policy Center, Urban Institute (May 2012) ; Milliman Market Analysis; 'and Washington Health Care Authority for Medicaid/CHIP enrollment.

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Medicaid Projections

	N
Currently Enrolled	1,095,254
Potential New Enrollees	1,039,228
Currently Eligible, Not Enrolled[1]	544,921
Newly Eligible Under Reform	494,307
Projected New Enrollment[2]	328,221
Currently Eligible, Not Enrolled	77,913
Newly Eligible	250,308

~429,000 have private coverage and most will retain that coverage.

Welcome Mat
~11,000 uninsured adults
~18,500 uninsured children
~30,500 insured children
~18,000 insured adults

Source: UI Analysis of Augmented WA State Database

1. This estimate may be an overstatement. Our data represent a single point in time; crowd-out provisions and other aspects of eligibility that require knowledge of an applicant's history could not be modeled.
2. We simulate the Medicaid expansion as if fully implemented in 2011

New Medicaid Enrollees Report Good Health Overall

	Eligibility of Projected New Enrollees					
	Currently Eligible, Not Enrolled		Newly Eligible		Total	
	N	%	N	%	N	%
Total	77,913	100.0%	250,308	100.0%	328,221	100.0%
Health Status						
Excellent - Good	58,726	**75.4%**	180,407	**72.1%**	239,133	**72.9%**
Fair - Poor	19,187	24.6%	69,901	**27.9%**	89,088	27.1%

Source: UI Analysis of Augmented WA State Database

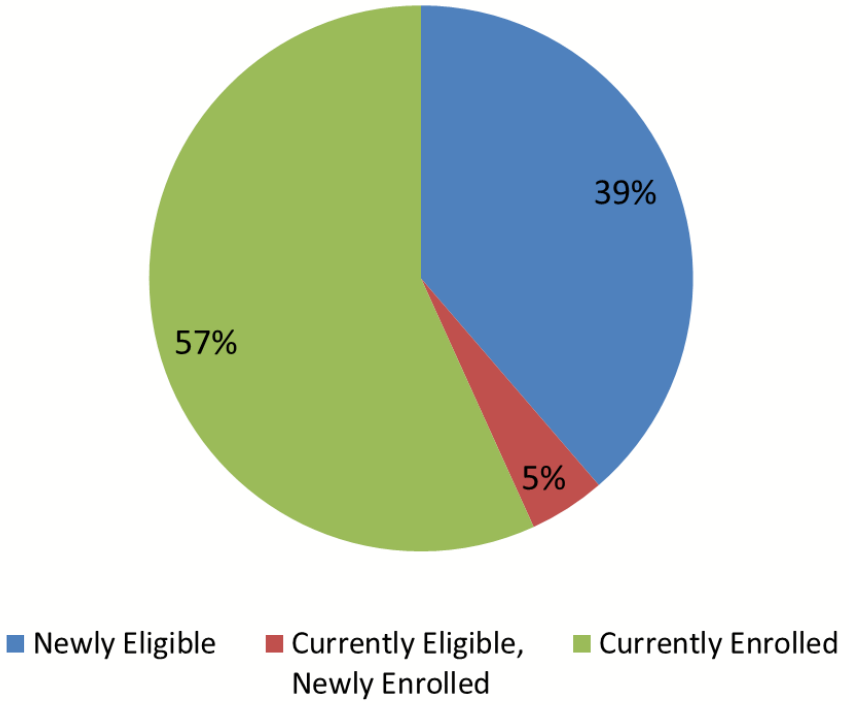
Age of New Medicaid Enrollees

- Newly eligible new Medicaid enrollees are almost exclusively adults
  - Unsurprising given current generosity of children's Medicaid/CHIP coverage
- New outreach under health reform will encourage currently eligible yet not enrolled children to take up Medicaid
  - 63% of currently eligible new Medicaid enrollees are 18 or under

Post ACA Implementation: Medicaid Enrollment of Nonelderly Adults

With Large Growth in Enrollment, Average Costs Decline

Reform: 633K Enrollees, Avg. Cost $7,293
(Baseline: 359K Enrollees, Avg. Cost $7,906)



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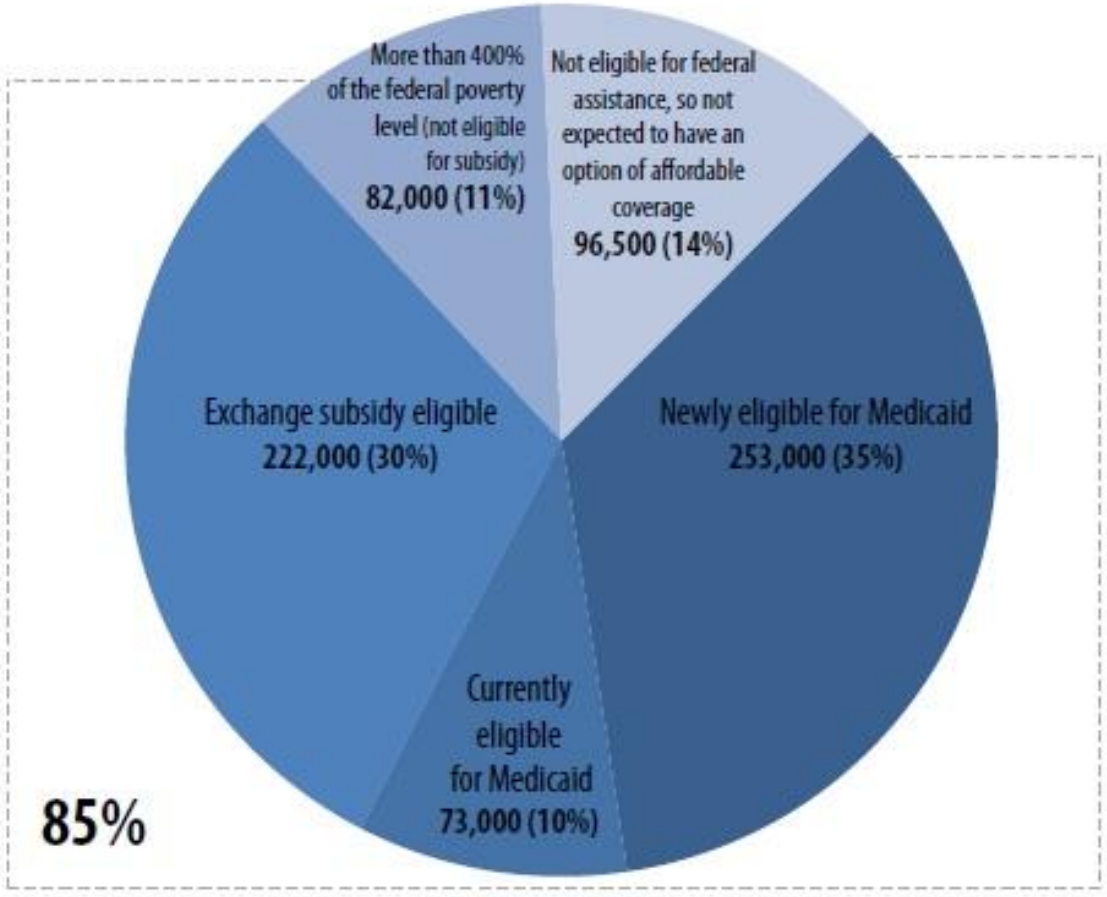
85% of Washington's uninsured adults will have access to affordable coverage under full implementation of the ACA



Source: Urban Institute Analysis of Augmented Washington database, 2012

Uninsured Groups Remain

- Undocumented immigrants
- Individuals exempt from the mandate who choose to not be insured (e.g., because coverage not affordable)
- Individuals subject to the mandate who do not enroll (and are therefore subject to the penalty)
- Individuals who are eligible for Medicaid but do not enroll

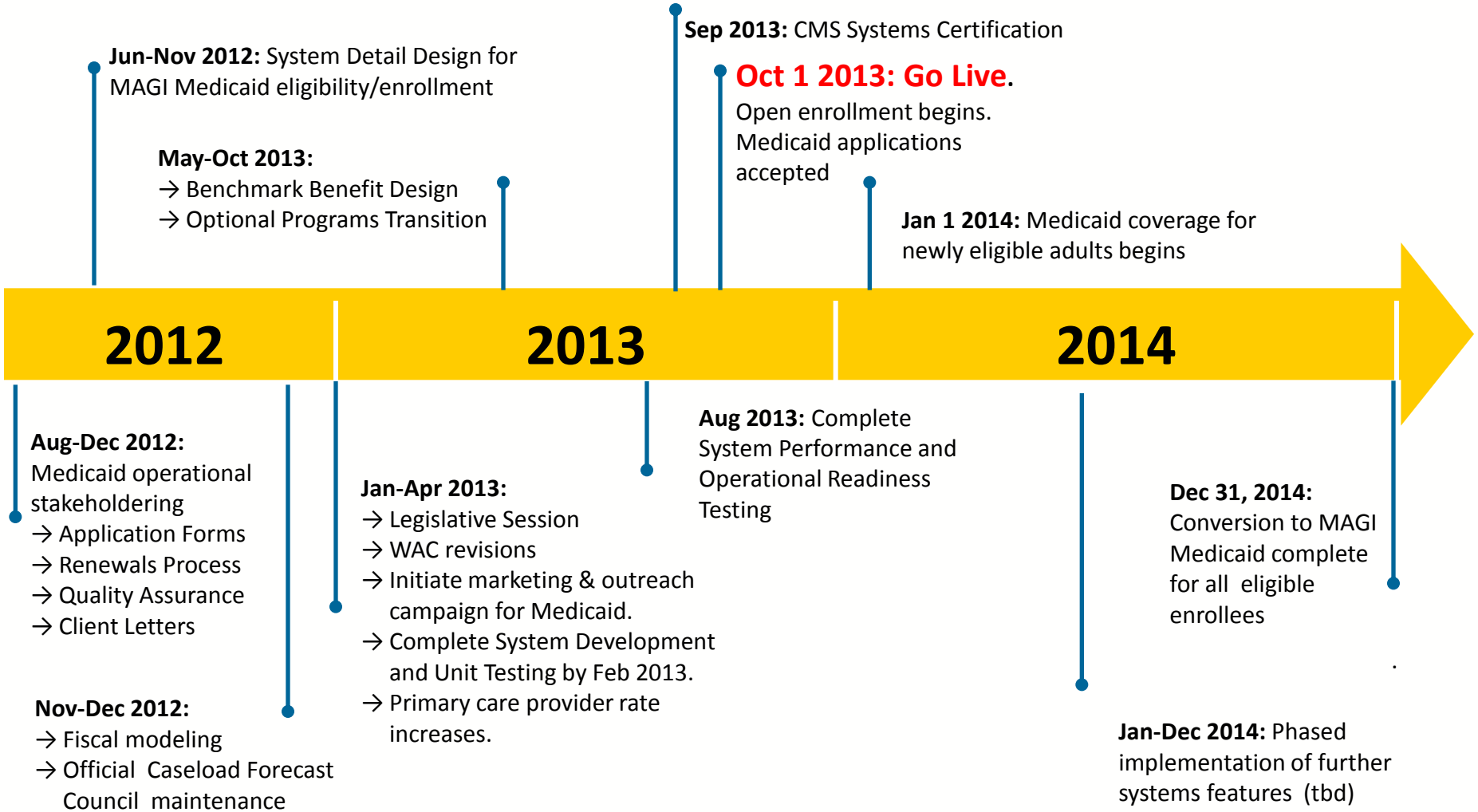
New Research on Primary Care Access

- Results from a recent survey of primary care physicians in WA state show that:
  - About 90 percent of primary care physicians provide care for some patients covered by Medicaid.
  - Close to 80% of primary care physicians are accepting new patients
    - Only 30% of this group are not including Medicaid covered clients in their expansion plans
    - Just over 20% reported that all their new patients could be Medicaid covered.

- Reports available include:
  - Characteristics and distribution of current primary care physicians
    - http://www.ofm.wa.gov/healthcare/deliverysystem/2011_PCP_survey_frequency_report.pdf
  - Availability of Primary Care Physicians to Serve the Medicaid Expansion
    - http://www.ofm.wa.gov/researchbriefs/2012/brief065.pdf
  - Primary care physician availability in non-urban areas (available upon request)

Ongoing Medicaid Expansion Policy Discussions

Timeline: Much Work to be Done!



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Medicaid Expansion Goals

- Optimize opportunities to streamline administrative processes
- Leverage new federal financing opportunities to ensure the Medicaid expansion is sustainable
- Maximize use of technology to create consumer-friendly application/enrollment/renewal experience
- Maximize continuity of coverage & care as individuals move between subsidized coverage options
- Reform the Washington way --- comply with, or seek waiver from, specific ACA requirements related to coverage and eligibility, as needs are identified

Key Questions

- **Budget** – what are the short and long-term implications of full/partial/no Medicaid expansion?
- **Opportunities for streamlining** – how can current processes and programs be effectively streamlined?
- **Benefit design for new adults** – what are the parameters for the new adult benefit package?
- **Whole family coverage/churn** – what options best support families whose circumstances change?

Fiscal Implications of Expanding Medicaid

- **The cost of covering newly eligible adults with the benchmark package of benefits, considering:**
  - Number of newly eligible who enroll -- no means-tested program ever achieves 100% take-up
  - Per member per year costs of newly eligible -- newly eligibles tend to be lower-risk
  - Fully federally funded from 2014-2016, with federal funding decreasing to 90% of costs in 2020+
- **The potential State savings from current Medicaid and state/locally-funded services, and additional State revenues, including:**
  - Current Medicaid populations move to new adult group with enhanced federal match
  - Costs of State-funded programs for the uninsured (e.g. mental health/substance abuse programs) will go down as population gains Medicaid coverage
  - State revenue increases from provider/insurer assessments & general business taxes on new Medicaid revenue
- **The broader economic value of additional health care dollars to the health care system and the State economy**
  - Reduced number of uninsured (increased access to care, fewer medical bankruptcies)
  - Increased revenue for providers
  - Increased employment in the health care sector

Costs of Not Expanding Medicaid

Consumers

Individuals whose incomes are too high for Medicaid but too low for Premium Tax Credits (less than 100% of the FPL) will have no coverage options and no tax subsidies for purchasing health insurance

Providers

Hospitals will face not only the continued costs of providing uncompensated care, but also a reduction in federal disproportionate share hospital (DSH) funding

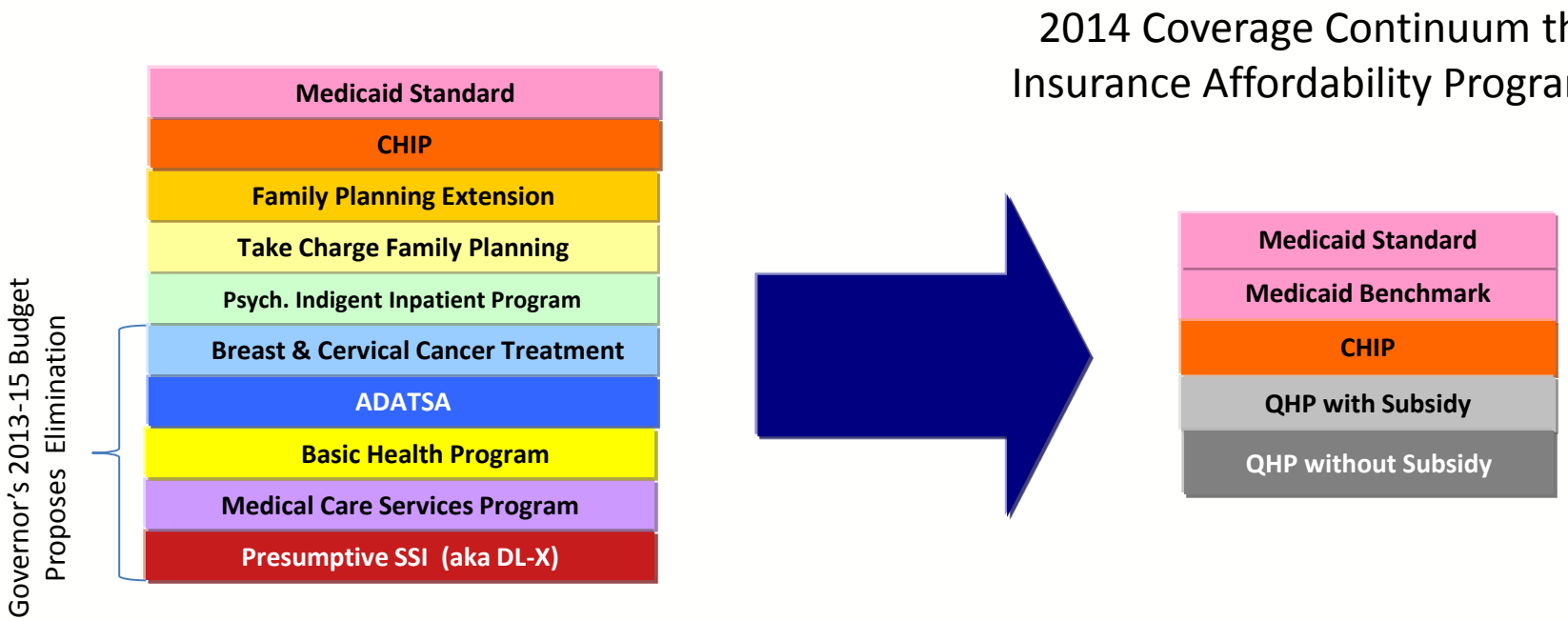
Employers

Employers will face new coverage obligations for individuals with incomes between 100% and 138% of the FPL; additionally, large employers will face a penalty if full-time employees in this income bracket obtain a premium tax credit through the Exchange

Exchange

Interfacing between State Medicaid programs and the Exchange will become very complex administratively, with many “hand-offs” and eligibility determinations conducted against a patchwork of existing state Medicaid categories with variable income levels

ACA Opportunity to Streamline Programs



Streamlining considerations – numbers affected, access/continuity of coverage through IAP continuum, administrative complexity, transition timing

Legal Requirements for Designing Washington's Benchmark Benefit (Alternate Benefit) Plan

ACA Benefits Terms of Art and Confusion

- Essential Health Benefits
- Essential Health Benefits Reference Plan
- Benchmark Coverage
- Base Benchmark Plan
- Alternative Benefit Plans

New Adult Group Receives Benchmark Coverage

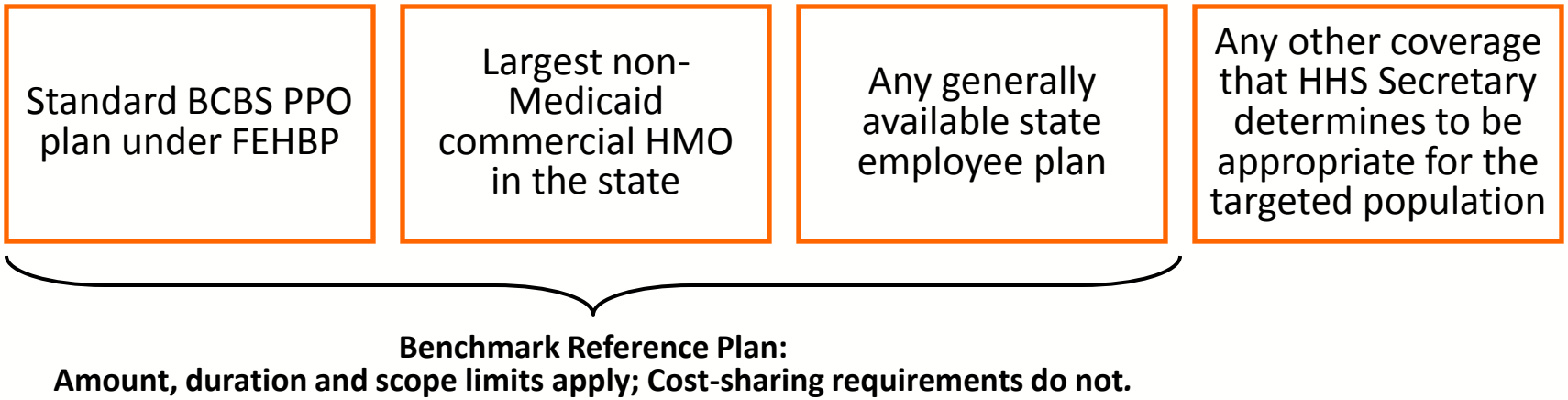
ACA establishes new, mandatory Medicaid eligibility group of non-pregnant adults between 19-65 with incomes ≤133% FPL

- This "new adult eligibility group" consists of childless adults, and parents/caretakers above ~40% FPL
- States must provide Benchmark or Benchmark-equivalent coverage described under §1937 of the Social Security Act (DRA), as modified by the ACA to adults in new adult eligibility group
- States will receive enhanced FMAP for "newly eligibles" within new adult eligibility group

Reminder: 133% = 138% FPL with 5 percent across the board disregard.

Benchmark Coverage Under the 2005 Deficit Reduction Act

Benchmark coverage linked to:



- Benchmark must cover:
  - EPSDT for any child under age 21 covered under the state plan
  - FQHC/RHC services
  - Non-emergency transportation
  - Family planning services and supplies
- State may supplement benefits in Benchmark reference plan

Benchmark Coverage Under the Affordable Care Act

Beginning in 2014, Benchmark must include all Essential Health Benefits (EHBs) for:

- new adult eligibility group (newly-eligible and currently-eligible)
- all existing Benchmark populations

EHB Categories:

- Ambulatory services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

EHBs and Medicaid Benchmark Coverage

- EHB reference plan for Medicaid may be different than EHB reference plan for individual/small group (Regence Innova).
- State must select an EHB reference plan for Medicaid.
  - State may select its full Medicaid package as its Benchmark coverage under "Secretary-approved" option but must also select an EHB reference plan.
  - State must specify EHB reference plan as part of 2014-related Medicaid State Plan changes.
- States must provide public notice and reasonable opportunity to comment before submitting State Plan Amendment with Benchmark plans to CMS.

Unlike in individual and small-group market:
- State may have more than one Benchmark for new adult group
- No default reference plan – State must choose

As of 2014, Mental Health Parity Applies to Benchmark

- Under current law, federal mental health parity (FMHP) requirements only apply to Medicaid managed care, not Medicaid fee-for-service.
- The ACA expands some FMHP requirements to all Benchmark and Benchmark equivalent plans
  - Mental health and substance abuse benefits must have parity with medical/surgical benefits with respect to:
    - Financial requirements (deductibles, co-pays, and coinsurance)
    - Treatment limitations (frequency/scope/duration)
  - Because Benchmark must cover EPSDT, it meets FMHP requirements for individuals under 21

Additional CMS Guidance 11/20/12 – More to Come

- Medicaid "benchmark" benefits now called "Alternate Benefit Plans."
- Initial Alternate Benefit Plans will be in effect for two years through December 31, 2015.
- SPA describing Alternate Benefit Plans may be submitted starting in the first quarter of 2013 for January 1, 2014 effective date.
- If State intends to implement Alternate Benefit Plan through managed care delivery system, amended managed care contract must be submitted to CMCS.

Alternate Benefit Plan Open Questions

- Is Washington required to include benefits covered in the selected EHB reference plan that are not covered in State's Standard Medicaid, e.g., chiropractic services or naturopathy?
- Must the State include in the Alternate Benefit Plan all services or providers in the selected reference plan including those that federal Medicaid does not cover, e.g., institutes of mental disease or fertility treatment?
- May the State include waiver services in its Alternate Benefit Plan?

Note: See http://www.hca.wa.gov/hcr/me/policies.html for WA request to CMS

Considerations for Designing Washington's Alternate Benefit Plan

Analysis Steps to Design Alternate Benefit Plan

- Select Medicaid EHB Reference Plan.
- Determine if selected EHB reference plan includes required 10 statutory categories for EHBs.
- Compare benefits across selected EHB Reference Plan and Medicaid Standard.
- Identify meaningful differences in coverage.
- Note where State may be required to include EHB-covered service in Alternate Benefit Plan and differences with Medicaid Standard.
- Conduct mental health parity analysis:
  - Cross-walk mental health and substance abuse services from EHB Reference plan to Alternate Benefit Plan
  - Apply Mental Health Parity

Additional Considerations in ABP Design

- Clinical needs of new adult population
- Alignment across Medicaid categories
- Alignment between Medicaid and QHP
- Administrative ease for beneficiary and State
- Whether and how to apply cost-sharing
- FMAP implications:
  - State receives enhanced match for newly eligibles
  - Populations in new adult eligibility group who would have been eligible for comprehensive benefits under another eligibility category as of Dec. 1, 2009 are not “newly-eligible”

Options for Alternate Benefit Plan(s)

- Align Alternate Benefit Plan to Medicaid Standard:
  - Add Alternate Benefit Plan benefits to Medicaid Standard
  - Add Medicaid Standard benefits to Alternate Benefit Plan

- Offer different benefit packages to different groups:
  - Alternate Benefit Plan to new adult group
  - Medicaid Standard to children, pregnant women, LIF parents and ABD

- Potential for cost-sharing?

Considerations for Designing Medicaid Cost Sharing

Overview of States' Cost-Sharing for Adults

- **Co-payments**:
  - 40 states require co-payments for select services from LIF parents enrolled in Medicaid.
  - 26 states require co-payments from adults in their Section 1115 Waiver or state-funded expansion programs.

- **Co-Premiums and enrollment fees:**
  - Two states (IL and WI) charge co-premiums to LIF parents with incomes at or greater than 150% FPL.
  - 21 Section 1115 Waiver or state-funded expansion programs apply co-premiums.

Source: Heberlein, M. et. al., for the Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, "Performing under Pressure: Annual Findings of a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost-Sharing Policies in Medicaid and CHIP, 2011-2012." January 2012.

Draft Cost Sharing Principles for WA

Medicaid expansion offers new opportunities to reconsider enforceable, limited, cost sharing for the new adult group to:

- Promote use of evidence-based cost-effective treatment while reducing low-value and medically unnecessary care;
- Avoid discouraging or creating barriers to essential and appropriate care;
- Avoid cost-sharing cliff between Exchange and Medicaid coverage;
- Maintain consistency with historical policy direction for low-income adults to contribute to their health care;
- Facilitate provider collection of required co-payments;
- Maximize use of consumer-friendly, administratively simple processes.

WA Experience with Cost-Sharing

- **Basic Health Plan** (income between 0-200% of FPL):
  - Premiums and cost sharing for all enrollees:
    - Premiums: based on age/income - start at $17/month
    - Co-Payments:
      - $15 co-payment for non-preventive office visit
      - $100 co-payment for non-emergent ER visit
    - Co-insurance/deductibles:
      - $250 standard deductible per person, then
      - 20% co-insurance for most services up to $1,500 annual out-of-pocket limit
  - Wait list of over 170,000 people indicates strong demand for program
  - No evidence that point-of-service cost-sharing served as a barrier for people accessing coverage.

- **Children's Health Insurance Program (CHIP**) (income between 200-300% FPL):
  - Premiums of $20 or $30 per child
  - No point-of-service cost sharing

- **Categorically Needy Medicaid** for children and adults:
  - No cost sharing or premium requirements

Cost Sharing "Strawman" for Discussion

- Limited, enforceable cost sharing for newly eligible adults between 100-138% of the FPL as a bridge to Qualified Health Plan coverage in the Exchange

- Preliminary 2014 implementation design
  - No premiums
  - No cost-sharing in Medicaid fee for service
  - Cost sharing through managed care plans only
  - Out of pocket costs tracked by managed care plans

- Align point of service cost sharing for Medicaid adults with Exchange adults at same income level

Whole Family Coverage/Churn Options

- Changes in circumstances cause churn across coverage
  (e.g., income, family or employment status, pregnancy, child birth)

- Differing eligibility levels potentially split families across different managed care plans and provider networks
  (e.g., children/pregnant mother in Medicaid, father in Exchange)

The Challenge = rationalizing and simplifying family coverage options

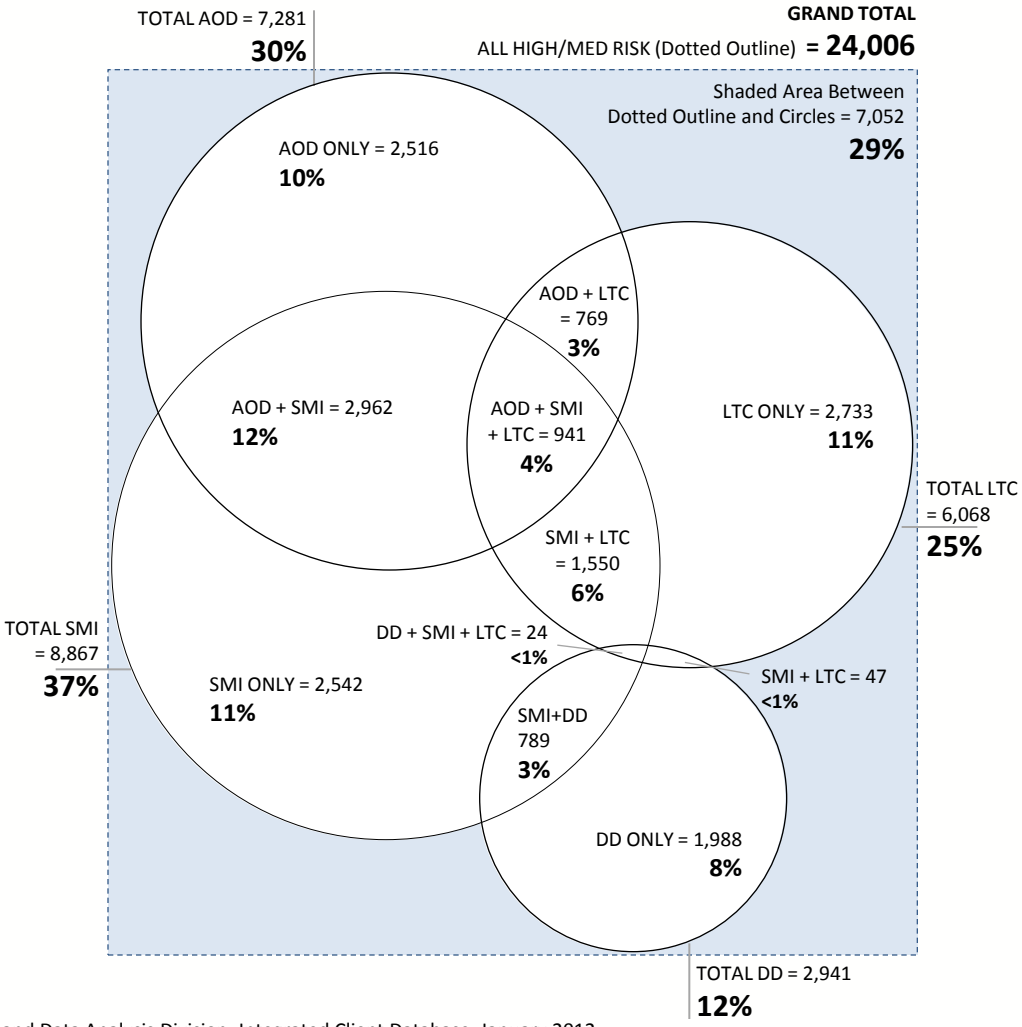
Complementary Reform Efforts

Washington State's Challenge

- Medicaid delivery system silos
  - Managed Care, FFS
  - County-based behavioral health
  - Dual-eligibles
  - Long-term Care
- Fragmented service delivery and lack of overall accountability
- Service needs and risk factors overlap in high-risk populations
- Incentives and reimbursement structures are not aligned to achieve outcomes
- Existing design is not sustainable

Service need and risk factor overlaps among high medical need Medicaid Only Disabled clients

STATE FISCAL YEAR 2009



SOURCE: DSHS Research and Data Analysis Division, Integrated Client Database, January 2012.

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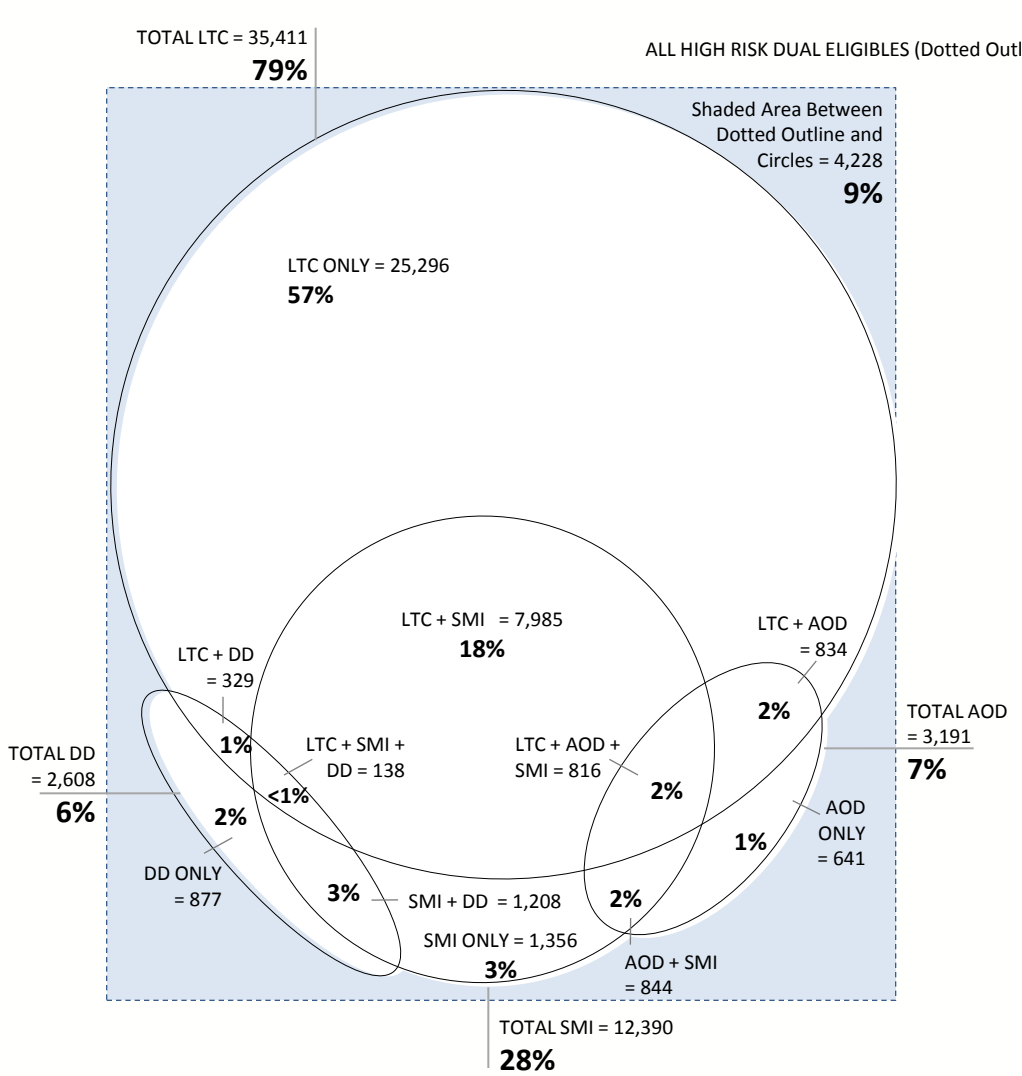
Service need and risk factor overlaps among high risk <u>DUAL ELIGIBLE</u> Aged or Disabled clients

STATE FISCAL YEAR 2009



SOURCE: DSHS Research and Data Analysis Division, Integrated Client Database, January 2012.

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Coverage Vision

- Organized systems of care with accountability for costs and outcomes
- Consumer-centric integration of medical, behavioral health and long-term care needs
- Preserve consumer choice and ensure access to qualified providers
- Reduce unnecessary utilization and duplication of services
- Align financial incentives for payers and providers
- Strike right balance between prescriptiveness and innovation

Strategy

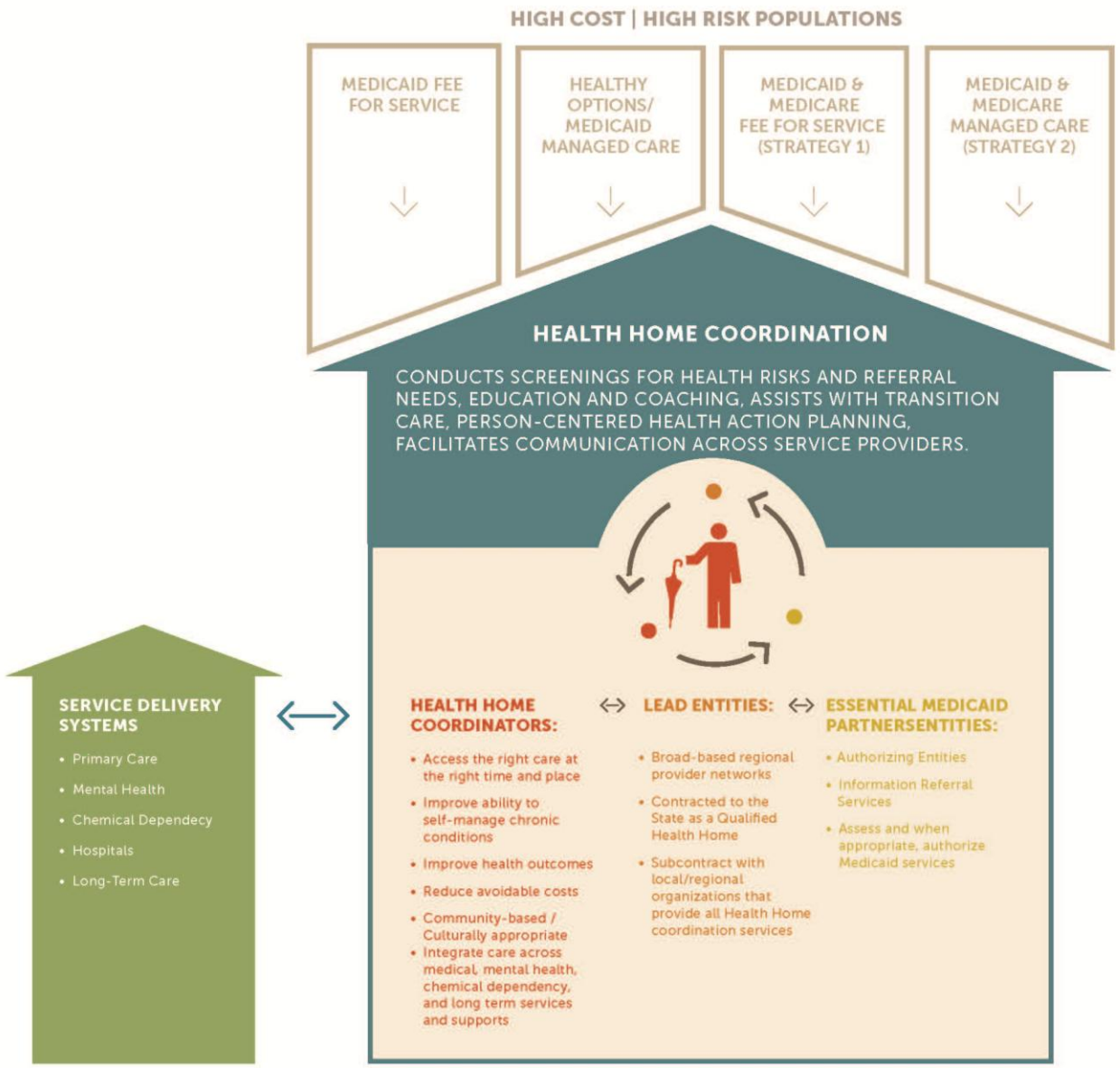
- Embed robust delivery of health home services to bridge across all systems of care
- A new set of discrete services targeted to high cost/high risk clients who need intensive care coordination
- Focus on personal heath action goals for beneficiaries

Desired Outcomes

- Improve the ability of Medicaid consumers to function in their home and community
- Slow the progression of disease and disability
- Access the right care, at the right time and right place
- Successfully transition from hospital to other care settings with necessary follow-up care
- Reduce avoidable utilization and unnecessary costs

A Health Home Provides Integrated Care For:

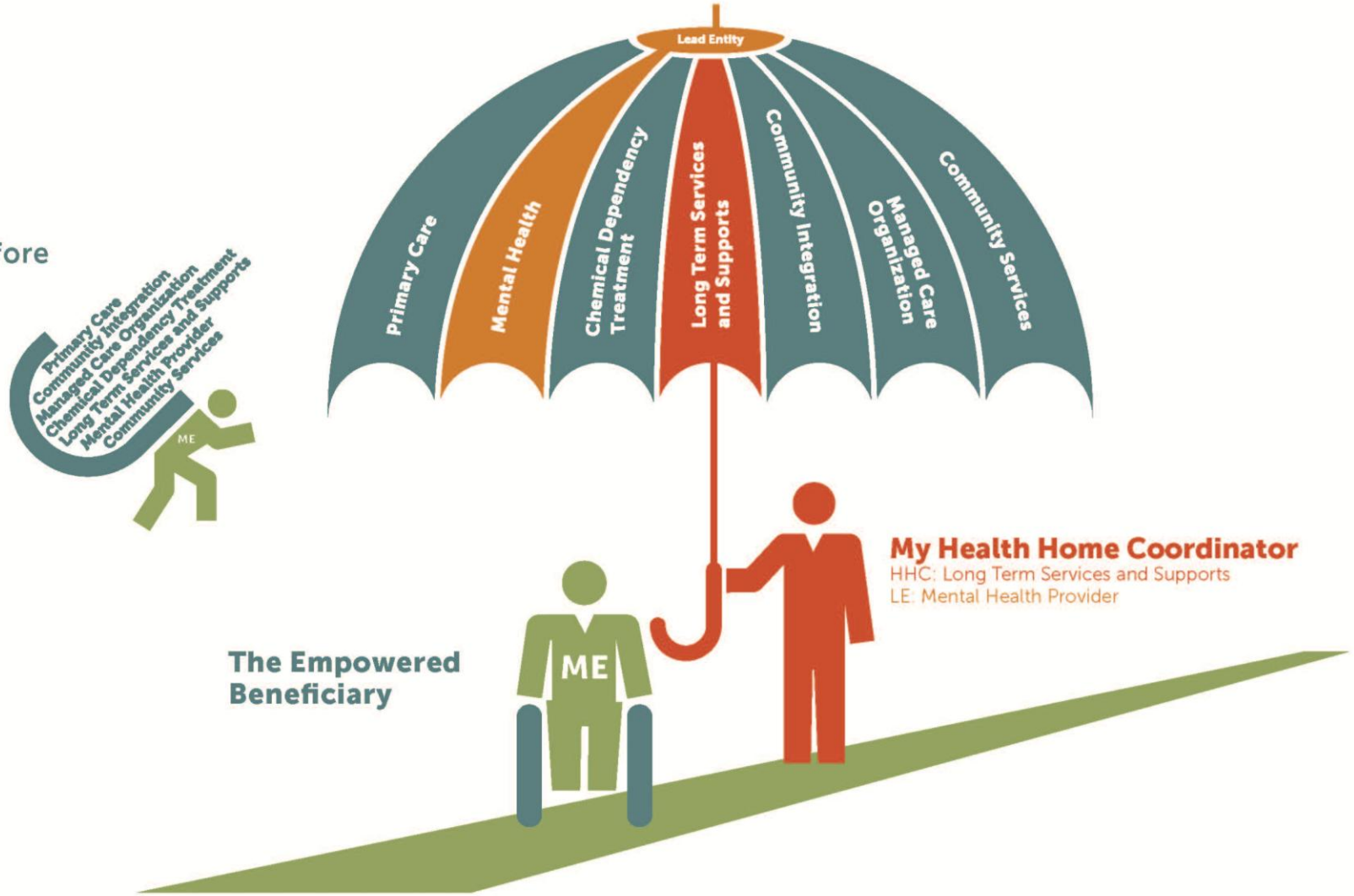
HealthPath Washington



After Health Home

My Health Home Coordinator
Lead Entity

HealthPath Washington



Washington State Health Care Authority

Coordination and Integration Create A Better Care Experience for the Beneficiary

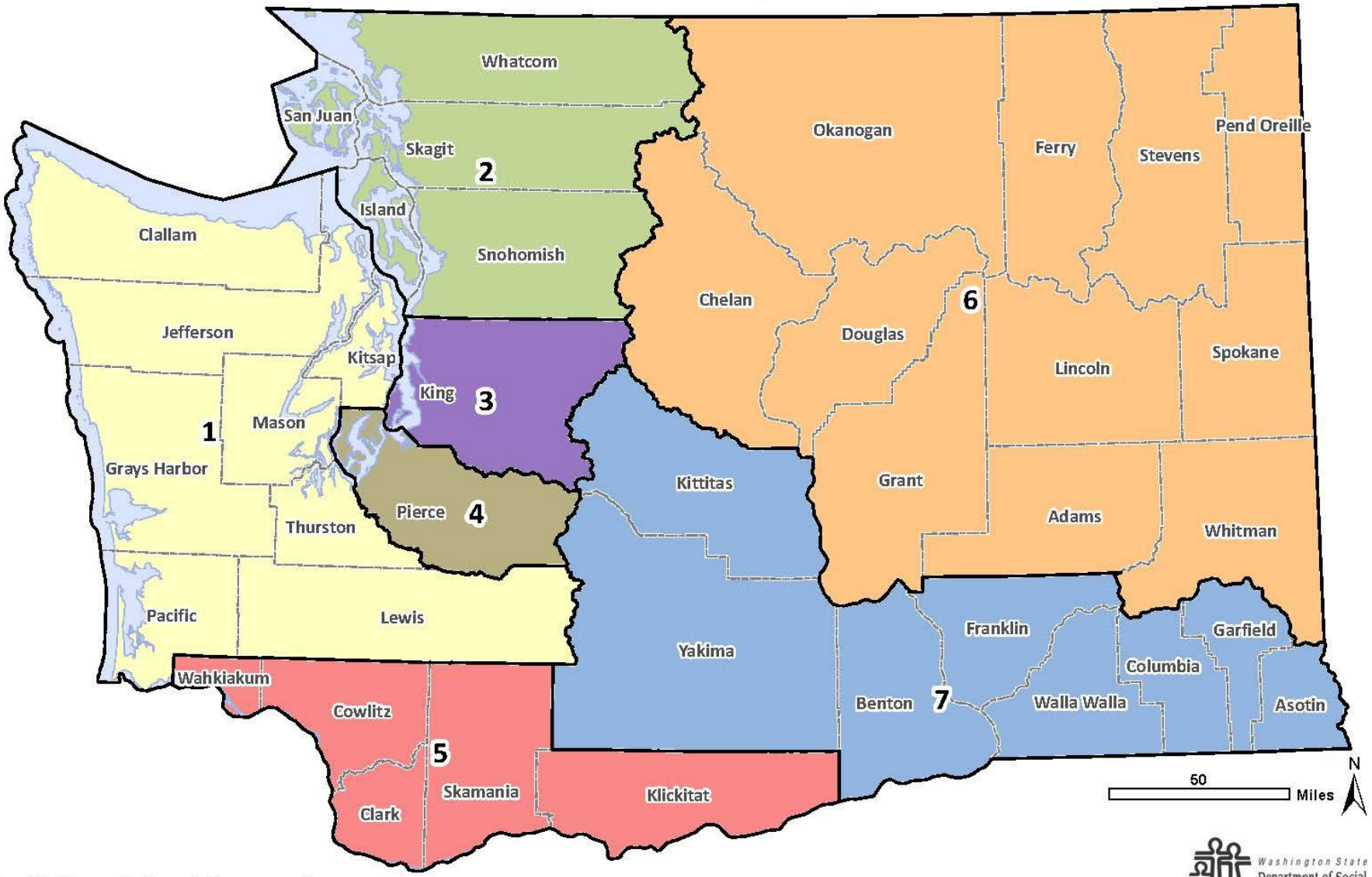
HealthPath Washington

Washington State Health Care Authority

Health Home Network Coverage Areas

Effective October 8, 2012

HealthPath Washington



Health Home Network Coverage Areas

1 2 3 4 5 6 7 County boundary

Washington State Department of Social & Health Services

RDA Research & Data Analysis Division

Sources: Health Home Network Coverage Areas: Health Care Authority, DSHS Aging and Disability Services Administration. Counties: 2010 TIGER/Line shapefile.

Map Created: October 11, 2012

Complementary Purchasing Paths

- Joint Procurement of Medicaid and Basic Health (2012)
- Medicaid Expansion – the new coverage continuum
- Integrated Care Pilots
- Multi-payer Medical Home Pilot
- Bree Collaborative
- Evidence-based purchasing initiatives
- CMMI Grant

See HCA Links for More Information

- Main HCA web-site: http://www.hca.wa.gov/
  - For information about the Medicaid expansion: http://www.hca.wa.gov/hcr/me
  - To contact the HCA concerning the Medicaid expansion: medicaidexpansion2014@hca.wa.gov
  - For demo on Deloitte Healthplanfinder (~2 hours) https://deloittemeetings.webex.com/deloittemeetings/ldr.php?AT=pb&SP=MC&rID=14808187&rKey=203bf4bc67d42b8b
- Webinars and presentations around the state
  - See upcoming schedule and past events at: http://www.hca.wa.gov/hcr/me/stakeholdering.html
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